

A survey of English NHS prescribing advisors' roles, and their views on improving prescribing in the new NHS

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AIM To ascertain the roles undertaken by NHS prescribing advisers in England, to identify the problems they encountered when attempting to improve local prescribing, to record their relationships with local drug and therapeutics committees and local research ethics committees, to summarise their beliefs on how NHS prescribing could be improved, and to predict how their roles may change in the new NHS.

Design A questionnaire was distributed at the National Prescribing Centre's annual conference in June, 1998, followed by contact with prescribing advisers in non-responding English health authorities. Subjects and setting Prescribing advisers employed by all health authorities in England. Outcome measures Responses to structured questions.

Results Most advisers were performing roles similar to those envisaged by the Conservative government during the early 1990s, with individual visits about specific issues being the most popular strategy for maintaining contact with local practices. The targeting of practices by pharmaceutical companies, the prescribing policies of local hospitals and patient demands were causing significant problems in their attempts to improve local prescribing. Over 80% of respondents were members of at least one local drug and therapeutics committee, while only 9% were members of their local research ethics committee. Approximately one third of respondents wished for more central guidance or greater controls on product licensing. Finally, 40% of respondents believed that the role of prescribing advisers would change significantly in the new NHS.

Conclusions In the new NHS, health authority prescribing advisers may provide more strategic direction, devise local policies and act as primary care group (PCG) prescribing co-ordinators. PCG advisers may provide practice visits and advice to PCG boards. To accompany these changes, health authority advisers may become involved in medicines management and PCG advisers in prescribing support, rather than individual practice visits.

During the early 1990s, the Conservative government introduced a range of initiatives designed to improve prescribing in National Health Service general practice.¹ At a national level, attempts were made to improve the prescribing data, educational publications and prescribing advice available to general practitioners. At a local level, family health services authorities (FHSAs) were instructed to introduce a range of measures designed to control the growth and variation in local drug costs and to promote rational prescribing.² To help meet these objectives, most authorities began to employ prescribing advisers to help audit local prescribing patterns and to provide advice on how individual practices could control their expenditure on drugs.³

In 1994, the Audit Commission published a report on prescribing in NHS general practice, which suggested that savings in the region of £425m could be made if GP prescribing was changed in the ways that the commission recommended.⁴ In its report, the commission suggested that pharmaceutical industry "hard-sell", hospital cost-shifting, patient demands and the launch of high-cost new products had all contributed to the growth in NHS expenditure on drugs. In response, the report recommended that, among other measures, prescribing advisers should perform more focused practice visits and that each FHSA should develop a local prescribing strategy.

Although both the government and the Audit Commission promoted a range of initiatives designed to alter NHS prescribing, many of the identified problems remained unresolved. In particular, the prescribing policies of local hospitals and the launch of high-cost new products led to growing pressure on pharmaceutical spending in many areas. In response, in 1994, all health authorities were instructed to establish a joint prescribing committee, which would involve prescribing advisers and other health care professionals in the development of local prescribing action plans.⁵ As part of these new arrangements, the committees were expected to work closely with the drug and therapeutics committees (DTCs) of local hospitals to manage the entry of new drugs and to improve prescribing across the primary-secondary care interface. At the same time, local research ethics committees (LRECs) were instructed to standardise the procedures that they used to review research applications, including local evaluations of new pharmaceutical products.⁶

Although prescribing advisers became central to efforts of many health authorities to change general practice prescribing, few attempts have been made to ascertain how they have performed their roles, or to seek their opinions on how NHS prescribing may be improved.⁷ In response, this paper reports the results of a survey designed to ascertain the sources of information that prescribing advisers use and how they undertake their roles, to identify the main problems they encounter when attempting to change local prescribing patterns, and to record their relationships with DTCs and LRECs. The paper also summarises respondents' beliefs about how NHS prescribing could be improved and how the roles that they perform may change once primary care groups (PCGs) have been introduced.⁸

Methods

The questionnaire constructed for this study consisted of a range of closed and open questions and was initially distributed at the National Prescribing Centre's annual conference in June, 1998. In order to increase the response rate, further questionnaires were distributed in November, 1998, to prescribing advisers in English health authorities from whom a reply had not been received, followed by reminder telephone calls in January, 1999. As a result of this approach, one response was received from an adviser in each of England's 100 health authorities. Although one response was received from each area, the views expressed were not necessarily representative of the health authority to which the respondents were attached.

Results

Over 90 per cent of respondents stated that they found the Drug and Therapeutics Bulletin, the National Prescribing Centre and the Bandolier useful sources of prescribing information (Table 1). Individual visits about specific issues were the most popular strategy for maintaining contact with local practices. The targeting of practices by pharmaceutical companies, the prescribing policies of local hospitals and patient demands were reported by a high proportion of respondents as causing significant problems in their attempts to improve local prescribing.

Questions	Percentage of "yes" responses
<i>Are the following useful sources of prescribing information?</i>	
<i>Drug and Therapeutics Bulletin</i>	98
National Prescribing Centre	97
<i>Bandolier</i>	91
UK Drug Information Pharmacy Group	84
Cochrane Collaboration	68
<i>How do you maintain contact with local  practices?</i>	
Visits to individual practices about specific issues	90
Regular newsletter(s)	77
Regular reports summarising practice prescribing patterns	59
Regular visits to all practices	58
Regular health authority meetings	43
<i>Do the following cause significant problems in your attempts to improve local prescribing?</i>	
Targeting of practices by pharmaceutical representatives	90
Prescribing policies of local hospitals	83
Patient demands for high-cost products	78
GPs with inadequate knowledge or training	65
GPs not responding to their PACT reports	53

Over 80 per cent of respondents were members of at least one DTC and worked in areas in which at least one committee was linked to the local district prescribing committee (**Table 2**). However, only 9 per cent were members of their LRECs and only 7 per cent reported that they were aware of all pharmaceuticals trials being undertaken in local hospitals.

Table 2. Relationship with drug and therapeutics committees and local research ethics committees

Questions	Percentage of "yes" responses
<i>Relationship with DTCs</i>	
Proportion reporting membership of a local DTC	89
Are any local DTCs linked to the district prescribing committee?	84
Do you think that local DTCs are effective at controlling prescribing costs in local hospitals?	54
Are local DTCs effective at controlling the shifting of drug costs from local hospitals on to local practices?	28
<i>Relationship with local ethics committee</i>	
Are you a member of the local research ethics committee?	9
From your perspective, could the committee do more to improve prescribing in your area?	57
Does the committee send you details of all trials of pharmaceutical products that it has approved?	18
Does the committee send you information about proposed trials of pharmaceuticals in your area, before they are approved?	11
Would you normally be aware of all trials of pharmaceuticals being carried out in hospitals within your health authority?	7

In **Table 3**, the 10 most frequent responses to the open question "What are the main ways in which NHS prescribing could be improved?" are given. Thirty-five per cent of respondents believed that more national guidance, direction or involvement from the NHS Executive was required, while 27 per cent believed that some form of restrictions on the type of drugs that were licensed or prescribable were desirable.

Table 3. Top 10 suggestions for improving NHS prescribing	
Responses	Respondents advocating approach (%)
More central guidance and direction	35
Tighter licensing, cost-effectiveness hurdle and black or white lists	27
Improve GP education, information and support	18
Improve secondary care prescribing	11
Restrictions on pharmaceutical industry, including product pricing	10
Improve patient education, involvement and demands	7
Greater use of incentive schemes and budgets	6
Increased use of practice-based pharmacists	6
Introduction of local protocols, guidelines or formularies	5
Change arrangements for dispensing doctors	5

Table 4 shows the 10 most frequent responses to the question "How in the future do you think that the roles of prescribing advisers should change?". Forty-three per cent of respondents suggested that health authority advisers should perform a strategic role helping developing local prescribing policies, and 36 per cent stated that they should work directly for PCGs providing advice to local practices.

Table 4. Top ten suggestions for changing advisors' roles in the new NHS

Responses	Respondents advocating approach (%)
Developing HA prescribing policies and strategies	43
Working directly for PCGs providing advice to local practices	36
Acting as a local prescribing co-ordinator and overseeing PCGs	17
Increased focus on performance management and governance	13
Increased emphasis on improving secondary care prescribing	9
Working with or co-ordinating community or practice pharmacists	8
Providing more expert advice and information	7
Developing local guidelines, protocols and formularies	6
Working on the managed entry of new drugs	3
Less involvement in budget setting and monitoring	3

Discussion

The questionnaire produced for this study was sent to prescribing advisers in England during the year prior to the introduction of the Labour government's plans for the new NHS. As a result, the questionnaire provided an opportunity to record how the previous Conservative government's initiatives had affected the roles undertaken by prescribing advisers in England and to record their views on how prescribing could be improved under the new system.

The results presented in **Table 1** suggest that the majority of advisers were performing roles similar to those envisaged by the Conservative government during the early 1990s and were using sources of information made available during, or before, that time. Despite the widespread adoption of the Conservative government's approach, many of the problems identified by the Audit Commission were still hampering the attempts of many advisers to alter local prescribing patterns and behaviour. For example, the targeting of practices by pharmaceutical company representatives, the prescribing policies of local hospitals and patient demands significantly affected the attempts made by many advisers to change local prescribing behaviour. Given these findings, the results of the questionnaire suggest that many of the initiatives championed by the Conservative government were limited in their ability to secure improvements in prescribing and that new, supplementary measures were required.

As **Table 2** shows, the majority of respondents had links with their DTCs (many of which were linked to their local prescribing committees). Despite this, a large number stated that the bodies could do more to

control prescribing costs in local hospitals and across the primary/secondary care interface. These responses suggest that the committees could not, in their existing form, have controlled all secondary care prescribing or countered the incentive for hospitals to shift their drug costs on to the community. Therefore, the results presented in **Table 2** suggest that many PCGs may work with their local DTCs and prescribing committees in order to develop more effective means of controlling the expenditure implications of hospital prescribing behaviour on primary care.

As advisers had detailed knowledge about proposed trials of new drugs in local practices, the results presented in **Table 2** suggest that advisers in many areas could have been helped in their attempts to fulfil their roles if they had had greater contact with, or information from, their LRECs. Indeed, such bodies could have warned advisers about the trials of new drugs and worked with them to help manage trial and post-trial drug costs. Despite these possible benefits, LRECs might have been constrained in their ability to provide such assistance because, in many instances, they might have been unable to make publicly available information about the commercially sponsored research that they reviewed.⁹

Although many of the problems identified by respondents were similar to those prevalent during the early 1990s, **Table 3** shows that many of the strategies previously advocated for changing NHS prescribing (such as the development of local formularies, the use of incentives and budgets and the employment of practice-based pharmacists) received little further support. There is also little correlation between the results presented in **Tables 3** and **4**, which suggests that many respondents believed that some of their major problems (for example, pharmaceutical representatives, hospital cost-shifting and patient cost) could not be directly addressed. Instead, they favoured a range of solutions that were, primarily, concerned with tighter national controls and an expanded role for pharmaceutical advice at a local level.

The results presented in **Tables 3** and **4** suggest that many of the Conservative government's initiatives had reached the limits of their effectiveness and that other, more effective measures were required. For example, a third of all respondents suggested that more central guidance and direction could have helped improve general practice prescribing and that greater controls should be placed upon products that are licensed or prescribable on the NHS. Given these responses, the results presented in **Table 3** suggest that the evaluation and co-ordination role planned for the National Institute for Clinical Excellence will be welcomed by many working within the new NHS.¹⁰

Finally, the questionnaire examined how the roles performed by prescribing advisers were likely to change in the new NHS. As **Table 4** illustrates, in the new NHS, health authority advisers may provide more strategic direction, devise local policies and act as PCG prescribing co-ordinators. PCG advisers, on the other hand, may provide practice visits, act as advisers to PCG boards and help implement the clinical governance agenda. In other words, health authority advisers may become involved in medicines management and PCG advisers in prescribing support rather than simply working to control the growth and variation in local drug costs. In consequence, the roles performed by individual advisers within the new NHS may greatly differ depending upon the problems faced by the areas and organisations in which they work.

Conclusions

The introduction of the new NHS is likely to see a change in the roles performed by general practice prescribing advisers. Health authority advisers are likely to become more involved in providing strategic direction, devising local policies and acting as PCG prescribing co-ordinators. PCG advisers, on the other hand, may supplement their traditional role of providing practice visits by providing advice to PCG boards and becoming more involved in prescribing support rather than promoting the control of local drug costs. The introduction of the National Institute for Clinical Excellence is likely to be welcomed by many of the advisers who advocated greater central direction and control and is likely to lead to the setting of local standards for prescribing and the monitoring of PCG performance against them.

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